AFTERCARE REPORT

Due: Monthly

(Fold and mail in window envelope or FAX when completed)

DOPL
ATTN: URAP
PO BOX 146741
SALT LAKE CITY UT 84114-6741

Questions? Call 530-6428 or 530-6718
FAX: (801) 530-6404.

MONTH: _____

ID #: _____

Name: _____

Profession:_____

DOPL is appreciative of the effort and support your program offers our probationers and diversionees. We consider your observations especially valid since you see them in a facilitated setting weekly. It is important that you keep us apprised of situations which could affect their recovery and advise us of anything which would be important in our efforts to assist them.

Week 1, Date:___/___/____ Comments/Observations:	**RELAPSE SYMPTOMS NOTED** ❑ YES
Week 2, Date:___/___/____ Comments/Observations:	**RELAPSE SYMPTOMS NOTED** ❑ YES
Week 3, Date:___/___/____ Comments/Observations:	**RELAPSE SYMPTOMS NOTED** ❑ YES
Week 4, Date:___/___/____ Comments/Observations:	**RELAPSE SYMPTOMS NOTED** ❑ YES
Week 5, Date:___/___/____ Comments/Observations:	**RELAPSE SYMPTOMS NOTED** ❑ YES

Random Drug Screens obtained? ❑ YES ❑ NO RESULTS:_____

Please discuss any comments, recommendations or problems for this probationer:

_____

_____

_____

Signature: _____ Date of Signature: ___/___/____

Name: _____ Institution: _____

Phone: _____

This document may be submitted by FAX to (801) 530-6404.